Special Article

"Heal Yourself"

GERALD BESSON, M.D., *Sunnyvale*

EDITOR'S NOTE: *"Heal Yourself" is a report of the Citizens Board of Inquiry into Health Services for Americans which seems to be destined for fairly wide dissemination. The approach is familiar and the findings deal harshly with health care in this nation. This report is unusual in that it carries with it an articulate "Dissenting Opinion" by Gerald Besson, M.D., of Sunnyvale who was an active and participating member of the Board. Because they believe his dissent is of broader interest than just this report, the editors have asked Dr. Besson to prepare an introductory statement summarizing the report to be published along with his dissent. Both Dr. Besson's "Introductory Statement" and his "Dissenting Opinion" are presented herewith.*

—MSMW

Introductory Statement

It has become quite fashionable these days to be critical of many shortcomings in our society. Indeed, this revolution in societal values, the questioning of meaning, purpose and quality of our lives represents a true discontinuity in civilization's progress and augurs well for our future. At the same time, there is a danger in the frequent lack of discernment between the good and the bad in our social institutions. All too often, critics overstate their case and imply that the only way to correct social inequities is to tear down the old and start anew with a clean slate. Besides the impossibility of implementing changes in that fashion, at least in our democratic society, there is a growing hazard to much that is of great value in our social institutions from the increasing acceptance of this approach. All too often what passes as conventional wisdom is merely repetition of uncritically accepted conclusions that are said to reflect public demand. Such demand then may stridently press for something, anything different from the old. And so it is with medicine.

Two years ago, the author was asked to serve on a Citizens Board of Inquiry into Health Services for Americans. The Board was created to focus attention on the consumers' perceptions of unmet needs in health services. It purported to bring attention to the consumers' story by interviewing users of health services in various parts of the country. It also interviewed providers and third party representatives. Out of these interviews developed a report published earlier this year entitled "Heal Yourself." * The report in its entirety should be read for a view of some sharp criticism of American medicine.

The Board's primary conclusion was that the medical profession had failed to provide adequate health services for the vast majority of citizens and as a result the awakening consumer was left angered and frustrated. Health services were obtained "only when sickness or injury forced consumers to muster the money and risk the obstacles and humiliations." Once the decision was made to seek care, "many Americans have no choice of where or from whom to seek it." "Patients who overcome the barriers to care" the report continued, "may find themselves treated with indignity and insensitivity, and sometimes the line between insensitivity and poor quality care is blurred."

The report described the inadequacies of

Dissenting Opinion reprinted from "Heal Yourself"—Report of the Citizens Board of Inquiry Into Health Services for Americans.

Reprint requests to: G. Besson, M.D., 877 West Fremont, Sunnyvale, Ca. 94087.

*Available from Citizens Board of Inquiry into Health Services for Americans—c/o Harry Huge, Executive Director, Arnold & Porter, 1229 19th St. N.W., Washington, D.C. 20036.

health insurance and hospital care as well as the providers acting from a narrow base of unrestrained professional interest. It decried decisions of the physician involving personal considerations that lead to overspecialization and maldistribution of providers.

Consumers are described as having "no real or effective role in the planning, organization or delivery of health care." And the report says further: "Like the doctors and the hospitals, the insurance industry has the consumer literally at its mercy. There is almost no opportunity for the health care consumer to influence the when, where and quality of services he receives or to determine how they should be paid for."

The recommendation of the Board to overcome the disarray of our health services is that it is "the responsibility of government, ultimately the federal government, to assure adequate health care for all Americans. Where care is inadequate, the federal government must become the residual guarantor, and, if necessary, the provider of health care."

The opinion submitted in rebuttal to the above summarized report follows.

Dissenting Opinion

This dissenting opinion is submitted because of some fundamental differences with the majority report. The undersigned, as a practicing physician and a concerned citizen, appreciates the opportunity to have served on this Board and the further opportunity to present this minority view.

There is an inherent bias in the rhetoric of the majority report, which serves no constructive purpose, and, in being accusatory rather than informative, does a disservice to a dedicated profession. Such rhetoric serves to undermine the cooperative effort between consumer, provider and government that is necessary if we are to correct the obvious and poignant inequities in the provision of health care.

It is regrettable that the provider is being discounted as a source of solution for the problems that this report documents. The right to health care must be guaranteed by our entire society, not the federal government alone. To suggest the latter would be a cruel hoax in raising expectations incapable of being fulfilled. The report, therefore, should have addressed our entire society, including the provider. To denigrate the responsible role the provider must share in guaranteeing the appropriateness, relevance and success of solutions is a disservice to our democratic processes and our pluralistic heritage.

There is a further inherent bias in the selection of consumers for interview which was neither cross-sectional nor representative of all our people. Granting the limitations of time, staff and money that precluded an exhaustive and scientifically sound inquiry, the opinion that resulted from the sampling seems to imply that there is nothing worthwhile in the entire health effort in this country. There is evidence to the contrary, and to deny it undercuts the credibility of this report.

There is, finally, a deep concern about the process of writing a report such as this. It was necessarily written by staff, although the Board was given ample opportunity to react to it. The manner of collecting material, interpreting and presenting it, could only reflect the authors' views, as modified by the Board. No amount of suggestion for change, however, could reconcile fundamentally disparate views, hence this minority statement.

This dissenting opinion rejects the contention of the majority report that it has presented evidence of the gross national inadequacy of health services. What is has done is present the view of those bereft of health care because of their poverty and those who, because of their socioculturally deprived life style, have strong deterrents to an optimal health state.

This dissenting opinion rejects the contention of the majority report that it has presented evidence for a single nationwide federal program as a solution for our health service problems. Such a simplistic conclusion is an interpretation that is neither supported by the interviews that make up the basis for this report, nor is based on hard data or dispassionate planning.

This dissenting opinion rejects the contention of the majority report that the consumers are powerless in relation to the provider. This cynical view completely ignores the existence of a professional ethic, the strength of consumer advocates and the rapidly emerging role of the consumer in all health policy matters.

This dissenting opinion rejects the inflammatory and emotional appeal by the majority report for crisis relief at any cost without concomitant long-range planning. Such an approach does not

do justice to the talents represented on this Board which are capable of sound inquiry, equitable judgment, and constructive proposals for change.

The following is a summary for the basis of this dissenting opinion:

(1) Adequacy of Health Services

There is no denying that many Americans have less than optimal health care. There is also no denying that the system may often be unresponsive to consumer needs. Nor is there any disagreement that we must, as a mature society, guarantee the right to health services for those in need, without the impediments of cost, inaccessibility or lack of responsiveness. The fundamental problem is to decide exactly how to achieve the greatest degree of equity in the provision of health services consistent with what our society establishes as its order of socio-economic priorities.

Health and Social Problems. While this entire report is ostensibly devoted to health, it is apparent to all that health is but a small aspect of one's socio-cultural well-being. To correct inequities in health care without simultaneously correcting inequities in housing, nutrition, education and environment is fruitless. One needs no documentation of the impact of poverty and its attendant evils on one's health state. To accuse the provider for these shortcomings, as the majority report implies, is inappropriate, as well as distracting from the basic problem. The problem is not lack of health services alone, but the entire culture of poverty. Culpability for these social problems cannot be laid at the feet of the provider. They are ageless and worldwide. We have an opportunity as a nation for the first time in history to overcome the deprivations of poverty and with it overcome the greatest impediment to adequate health services.

Health services also represent only a small fraction of one's general health state. The larger amount of one's health state revolves about life styles and habits, as well as his social environment. No amount of change in our health delivery systems will overcome the deaths attributable to auto accidents, smoking, or dietary excesses, to name only a few. Mortality statistics cannot be considered in a vacuum. A death from a late diagnosis of tuberculosis is no less than a death due to an overdose of heroin. Studies of smokers clearly reveal a diminution in life expectancy of the heavy smoker by eight years, compared with the non-smoker. More than 600,000 persons in the United States die annually from heart disease. Consideration of parameters such as stress, smoking, lack of exercise and diet, all of which are matters of life styles, lends a somewhat different perspective on the true nature of the problems of health in this country. It may well be that the greatest area for improvement in the health state of the American public lies not in the improvement of health services, but rather with education and the assumption of individual responsibility for healthful life styles.

Health Services. There is no dispute that health services should be accessible, immediate, personal, unhurried, continuous, concerned and excellent, with no financial barriers. This is an ideal state and we should work towards it. It is a state of health care that is available to many in this country and it should be available to all. In a study done in our area [California], 1,500 households were involved in a survey of health needs. The sample was one-half of one percent of all households in the county. It was a statistically sound cross section of income, race, ethnic origin and geography. Our final results are not collated but it was surprising to find that 72 percent of respondents who were asked a series of questions about their care were satisfied with their health services. They were satisfied specifically with availability, accessibility and acceptability. While this was a small sample in one small corner of this great country, it was interesting enough for us to pause and wonder whether our perceptions of the inadequacy of health services in this country are based on dispassionately acquired data, or whether they are based on reports of that portion of our population that is devoid of optimal care and does need assistance. Shall we then base our decisions on national health policies on health services research or on political reactions to the selected anecdotes presented in the majority report?

(2) Disarray of our Health Delivery Systems

The problem also is stated to be that our health delivery systems are inefficient and uncoordinated and what is needed is a rational nationwide system. Furthermore, the majority re-

port continues, the marketplace is inappropriate for the provision of health care and should be dispensed with.

The concept of disarray, in contrast to orderliness, is a semantic trap. One could hardly argue against rationality, responsiveness, or orderliness, yet what do we hope to achieve in providing personal health care if not, in the ideal, an intensely personal service responsive to the patient's needs. Disarray, in one man's view, may well represent ideal personal encounter in another man's view. Nor can the so-called inefficiency of the personal encounter be faulted. On the contrary, anyone in need of health services needs, if nothing else, personal encounter. All our service industries do not lend themselves readily to the kind of productivity that has characterized our industrial economy. The healing arts, particularly, involve the human touch and the dedicated concern of a selfless and knowledgeable professional. To sacrifice this in the name of efficiency and a coordinated system would run against the tide that is rising in our national consciousness that the primary function of our institutions should be the fulfillment of human needs. This must be our focus and to ignore it would serve to increase the depersonalization and alienation that is so widespread today.

How then, are these needs best to be served, if not to provide for all what is possessed by those who are satisfied with their care. There are impediments and these should be removed. Manpower must be expanded as a vital national resource. Cost efficiencies must be enhanced by a variety of techniques, such as computer assistance, automated laboratories, peer review, ancillary health personnel and cost accounting. Any impediments to the growth of alternate delivery systems must be removed.

But diversity of choice cannot be so cavalierly dismissed by instituting a planned new delivery system for all. It is the marketplace that allows for the greatest sensitivity to individual needs. It is limitless in the options available, allows the one who *wants* to do the choosing as he sees fit, rather than having someone choose for him, is devoid of moralizing and draws no distinction among those who purchase. Against these benefits are the obvious critical shortcomings that needs are subservient to ability to pay. While it is true that the harsh inequities of the market economy would be corrected by a new delivery system, other inequities will surely take their place. The forcing of our entire health venture into a single monolithic system, as the majority report recommends, would tend to freeze mistakes, stifle personal choice, diminish quality, and junk our pluralistic heritage. The public interest would be far better served to retain those portions of our system that are satisfactory, to restructure those aspects of our system that are unsatisfactory, and to create new ones where they are lacking. Pluralism in the provision of health services should be maintained. A basic minimum can be provided for all in this context.

(3) Centralized vs. Decentralized Loci of Authority

In some circles there is a conventional wisdom that the majority report promulgates, that if there is a problem that affects us all, the solution must be provided by the federal government. This is often expressed by cliches suggesting that the federal government must assume responsibility if individuals or institutions don't do what needs to be done or if they solve problems in a piecemeal rather than a national fashion.

Inherent in these arguments is the idea that there is an omniscience and omnipotence in Washington which would provide by a stroke of the pen on just the right document the instant and all-pervading solution. Nothing could be further from the truth, as is painfully evident to all citizens who have recognized the vast gulf between federal promise and performance. Our only protection against this gulf is to keep the locus of decision as peripheral as possible and maintain a regional and local approach to solutions that allow for the greatest degree of responsiveness possible. This is the basis on which the Partnership for Health and Regional Medical Programs are functioning and both are attracting wide attention as successful models for federal, state and local relationships. Within broad guidelines from the center, the locus of decision and authority functions best when kept as close as possible to the source of need.

Implied threats of assumption of authority by Washington are empty because an informed citizenry is well aware of the technical impossibility of the provision of services by the federal establishment or the instant creation of an entire new infrastructure for the provision of health services.

The federal role in this context is best described by the report of the Task Force on Medicaid and Related Programs: "The task force sees management of the system as given direction by federal leadership, specifically in the Department of Health, Education and Welfare. As is envisioned and recommended here, the management function for the health care system is to be innovative but not prescriptive; bold, but not authoritarian. It is the intention that the federal leadership, as far as possible, shall guide, not direct; motivate, not demand; assist, not provide; and evaluate, not ordain."

(4) Consumer Control in Health Policy

There is no question that the entire health effort must be focused on consumer needs. Any institution devoted to health services, old or new, must have a structure responsive to the consumer.

In the absence of this responsiveness, no amount of consumer control will bring about a desired end. The critical aspect of the consumer's position must be to have a formal opportunity for molding the institution to his needs. In the relationship between patient and physician, this is done in endless encounters based on mutual trust and the satisfying of patient needs. If the institution is other than a one-to-one patient-physician encounter, the establishment of policy must be based on a dialogue between provider and consumer by bringing both representatives together to see how needs are not being fulfilled. Policy decisions must be joint decisions. What is important is the creation of an established methodology for assuring both the dialogue and response to the decision. In this context, the seat of power is of secondary importance, since both provider and consumer are indispensable to the service.

The early history of consumer-dominated organizations for health care delivery has been extremely variable and not all favorable. Some Comprehensive Health Planning Agencies, Neighborhood Health Centers, and Regional Medical Programs have demonstrated a brilliant coordinated effort between provider and consumer. However, often the consumers' numerical presence is a ruse for the retention of an inadequate but established lack of responsiveness. Where policy decisions must be based on technical competence, the inept organizational structure that allows such decisions to be made by the consumers who don't have such technical competence undercuts the credibility of the organization. Consumer representation is also often only a token by the choice of acceptable but impotent representatives.

This minority report agrees that consumer representation must not be a sham nor should providers be responsible for contribution to policy decision if there is any conflict of interest. The essential ingredients for an effective, responsive institution are clearly articulated needs, shared control and responsiveness of provider to policy-making bodies that function as community trustees. The majority report seems to be a clarion call only for the assumption of power and not a search for equity.

(5) Planning—Problem Solving vs. Goal Achievement

The majority report calls for an urgent response to a crisis in health care. Perhaps the greatest difficulty encountered by planning groups, however, is the juxtaposition of planning for the achievement of long-range goals and, at the same time, solving urgent problems. Our national health effort has been characterized by an emphasis on the latter and the almost complete ignoring of the former. Both are simultaneously necessary. Unless we set our goals for some fixed time in the future and plan a series of intermediate objectives along a reasonable time scale, we can never move towards the realization of aspirations, except accidentally in the course of heading off one crisis or another. The current stampede towards a universal Federal Health Insurance Program exemplifies the dilemma. No amount of delivery system restructuring or payment mechanisms restructuring can provide adequate care without expanding our manpower resources simultaneously. As we embark on a new national venture in the absence of long-range plans, we will replace present crises with new ones.

It is in this context that this minority report expresses its greatest concern. There is no denying that the poignant inequities described in the majority report do exist. It is feared, however, that the emotionalism engendered by the presentation will serve as a stimulus for the further headlong rush, without planning and rational study, into a system that may create more prob-

lems than it will solve and leave us further from the ideal than previously.

By all means, let us jointly work towards solving our pressing health problems as equitably and expeditiously as possible. But let us also, at the same time, define our long-range ideals and set about systematically for their achievement.

Conclusions: This minority report is presented not to dispute the documentation of need and inequities described by the majority report but rather to have the reader consider the conclusions reached based on the following caveats:

That personal health is part of one's milieu. It cannot be improved alone but in the context of other basic social conditions.

The health services contribute to but a small part of one's health state. Mounting a national effort to enhance health services without affecting life styles and the hazards of our culture and environment will do little to ameliorate our national health state.

That in the absence of a dispassionately acquired body of knowledge about health services, we may grossly misdirect a national health effort based on political reaction to poignant anecdotal wisdom.

That in our zeal and our passion for order, we may uncritically reject the primacy of the unhurried human touch in the rendering of personal health services and sacrifice it to the efficiency of a single monolithic health system.

That the obvious inequities in our health care are correctable without relegating the provision of care to the federal government or a new health care infrastructure. Manpower shortages are amendable by the expansion of this national resource. Distributive shortages are amendable by periods of obligatory service or financial incentive. Individual poverty or medical indigency may be amendable by the provision of funds for those in need. Delivery systems that are inadequate for the culture of poverty may be restructured to meet those needs.

That dialogue between provider and consumer acting as community trustees rather than power struggles of vested interests will best serve consumer needs.

That the locus of authority for health decisions should be as peripheral as possible. Central function should be to provide coordination, guidance, and resource assistance.

That solving health crises alone will only replace one set with another. There is urgent need for concomitantly planning our future in health care and achieving it only by incremental achievement of intermediate planned objectives.

That ultimately our problems revolve around our choice of national priorities. Human needs and the quality of our lives must be our focus. Our affluent society cannot tolerate the gross social inequities that this report documents. In the necessities of life, a basic minimum for all is economically feasible, just and timely.

TREATING THE PAIN OF AORTIC ANEURYSM

We think it's very important in the patient with an acute dissecting aortic aneurysm to relieve pain. For instance, if the patient comes in with severe back pain, we lower the blood pressure to an appropriate level, and the back pain is relieved; then we feel comfortable in assuming that the dissection has been arrested and that everything is under control. On the other hand, if we lower the blood pressure and the pain is not relieved, we think this means the dissection has not been arrested and further measures must be taken. Under such circumstances, we would not hesitate and have not hesitated to lower the blood pressure to 70 or 80 mm of mercury systolic, provided the patient could continue to maintain a urinary output of a minimum of 25 mm per hour. In other words, one looks at the cerebration and the pain on one end and the urinary output at the other and this is the way these patients are monitored clinically.

—MYRON W. WHEAT, JR., M.D., Gainesville, Fla.
Extracted from *Audio-Digest Internal Medicine*, Vol. 17, No. 8, in the Audio-Digest Foundation's subscription series of tape-recorded programs. For subscription information; 619 S. Westlake Ave., Los Angeles, Ca. 90057